MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes (X) No
Requestor's Name and Address Surgical and Diagnostic Center, LP 729 Bedford-Euless Road West, Suite 100 Hurst, TX 76053	MDR Tracking No.: M4-04-4719-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance **Box 28** P.O. Box 40460 Houston, TX 77240-0460	Date of Injury: Employer's Name: Able Machinery Movers Inc. Insurance Carrier's No.: 973416595

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
3/11/03	3/11/03	29877	$2,198.34	$218.42
3/11/03	3/11/03	80059	$150.00	$0.00
3/11/03	3/11/03	86311	$50.00	$0.00
3/11/03	3/11/03	50058	$34.00	$0.00
3/11/03	3/11/03	93005	$35.00	$0.00
3/11/03	3/11/03	93010	$15.00	$0.00
TOTALS			$2,482.34	$218.42

PART III: REQUESTOR'S POSITION SUMMARY

Our charges are fair and reasonable based on other insurance companies' determination of fair and reasonable payment of 85% - 100% or our billed charges. Workers' compensation carriers are subject to a duty of good faith and fair dealings in the process of workers' compensation claims.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent believes that the reimbursement made to the provider is considered to be "fair and reasonable" and that they are in compliance with rules and regulations. The methodology used by the carrier is based on October 2002 Medicare ASC group rates, and carrier chose to reimburse facilities at 200% of that Medicare rate.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that neither the requestor nor the respondent provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). The failure to provide persuasive information that supports their proposed amounts makes rendering a decision difficult. While the requestor's requested amount appears inflated, the respondent's recommended amount appears deficient. After reviewing the services, the charges, and both parties' positions, it is clearly evident that some other amount represents the fair and reasonable reimbursement.

Prior to December 2004, Medical Dispute Resolution approached this type of review heavily from a "burden of proof" perspective. Unfortunately, this type of approach generally resulted in an "all or nothing" orders, which may not have been "fair" to either party. Accordingly, a new approach or methodology had to be established.

The primary driver of Medical Dispute Resolution actions is our role in resolving these fee disputes. Pursuant to Texas Labor Code

§413.031(b), our role in these cases is to adjudicate the "payment" given the provisions of the Act and rules. We must determine the reimbursement payment amount that should be ordered for a particular dispute, not just weigh "burden of proof" arguments.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities (from 192.6% to 256.3% of Medicare, for this particular year - 2003). In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not binding in nature, the ranges and information developed in this process provided a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedure in this case to the amount that would be within the reimbursement range recommended by the Ingenix study. Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, staff selected a reimbursement amount in the low end of the Ingenix range. The total amount was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommended amount, discussed the facts of the individual case, and selected the appropriate "fair and reasonable" amount to be ordered in the final decision.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that the fair and reasonable reimbursement amount for these services are $1,238.42, less the $1,020.00 already paid by the insurance carrier.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $218.42. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	08/11/05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box 28 on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____